

ASSEMBLY BILL

No. 2375

Introduced by Assembly Member Dababneh

February 21, 2014

An act to amend Section 100503 of the Government Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2375, as introduced, Dababneh. California Health Benefit Exchange: navigators.

Existing law establishes the California Health Benefit Exchange within the state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law also requires the board to establish the navigator program, and to select and set performance standards and compensation for navigators.

This bill would require the board to ensure that the performance standards selected for navigators are not so burdensome as to prevent a qualified entity from applying.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 100503 of the Government Code, as
- 2 amended by Section 4 of Chapter 5 of the 1st Extraordinary Session
- 3 of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. The board may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers

1 supplemental coverage in the Exchange under paragraph (10) of
2 subdivision (a) of Section 100504.

3 (f) (1) Except as otherwise provided in this section and Section
4 100504.5, require, as a condition of participation in the Exchange,
5 carriers that sell any products outside the Exchange to do both of
6 the following:

7 (A) Fairly and affirmatively offer, market, and sell all products
8 made available to individuals in the Exchange to individuals
9 purchasing coverage outside the Exchange.

10 (B) Fairly and affirmatively offer, market, and sell all products
11 made available to small employers in the Exchange to small
12 employers purchasing coverage outside the Exchange.

13 (2) For purposes of this subdivision, “product” does not include
14 contracts entered into pursuant to Part 6.2 (commencing with
15 Section 12693) of Division 2 of the Insurance Code between the
16 Managed Risk Medical Insurance Board and carriers for enrolled
17 Healthy Families beneficiaries or contracts entered into pursuant
18 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
19 (commencing with Section 14200) of, Part 3 of Division 9 of the
20 Welfare and Institutions Code between the State Department of
21 Health Care Services and carriers for enrolled Medi-Cal
22 beneficiaries. “Product” also does not include a bridge plan product
23 offered pursuant to Section 100504.5.

24 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal
25 act, a carrier offering a bridge plan product in the Exchange may
26 limit the products it offers in the Exchange solely to a bridge plan
27 product contract.

28 (g) Determine when an enrollee’s coverage commences and the
29 extent and scope of coverage.

30 (h) Provide for the processing of applications and the enrollment
31 and disenrollment of enrollees.

32 (i) Determine and approve cost-sharing provisions for qualified
33 health plans.

34 (j) Establish uniform billing and payment policies for qualified
35 health plans offered in the Exchange to ensure consistent
36 enrollment and disenrollment activities for individuals enrolled in
37 the Exchange.

38 (k) Undertake activities necessary to market and publicize the
39 availability of health care coverage and federal subsidies through
40 the Exchange. The board shall also undertake outreach and

1 enrollment activities that seek to assist enrollees and potential
2 enrollees with enrolling and reenrolling in the Exchange in the
3 least burdensome manner, including populations that may
4 experience barriers to enrollment, such as the disabled and those
5 with limited English language proficiency.

6 (l) Select and set performance standards and compensation for
7 navigators selected under subdivision (l) of Section 100502. *When*
8 *selecting and setting performance standards, the board shall ensure*
9 *the standards are not so burdensome as to prevent a qualified*
10 *entity from applying to be a navigator.*

11 (m) Employ necessary staff.

12 (1) The board shall hire a chief fiscal officer, a chief operations
13 officer, a director for the SHOP Exchange, a director of Health
14 Plan Contracting, a chief technology and information officer, a
15 general counsel, and other key executive positions, as determined
16 by the board, who shall be exempt from civil service.

17 (2) (A) The board shall set the salaries for the exempt positions
18 described in paragraph (1) and subdivision (i) of Section 100500
19 in amounts that are reasonably necessary to attract and retain
20 individuals of superior qualifications. The salaries shall be
21 published by the board in the board's annual budget. The board's
22 annual budget shall be posted on the Internet Web site of the
23 Exchange. To determine the compensation for these positions, the
24 board shall cause to be conducted, through the use of independent
25 outside advisors, salary surveys of both of the following:

26 (i) Other state and federal health insurance exchanges that are
27 most comparable to the Exchange.

28 (ii) Other relevant labor pools.

29 (B) The salaries established by the board under subparagraph
30 (A) shall not exceed the highest comparable salary for a position
31 of that type, as determined by the surveys conducted pursuant to
32 subparagraph (A).

33 (C) The Department of Human Resources shall review the
34 methodology used in the surveys conducted pursuant to
35 subparagraph (A).

36 (3) The positions described in paragraph (1) and subdivision (i)
37 of Section 100500 shall not be subject to otherwise applicable
38 provisions of the Government Code or the Public Contract Code
39 and, for those purposes, the Exchange shall not be considered a
40 state agency or public entity.

1 (n) Assess a charge on the qualified health plans offered by
2 carriers that is reasonable and necessary to support the
3 development, operations, and prudent cash management of the
4 Exchange. This charge shall not affect the requirement under
5 Section 1301 of the federal act that carriers charge the same
6 premium rate for each qualified health plan whether offered inside
7 or outside the Exchange.

8 (o) Authorize expenditures, as necessary, from the California
9 Health Trust Fund to pay program expenses to administer the
10 Exchange.

11 (p) Keep an accurate accounting of all activities, receipts, and
12 expenditures, and annually submit to the United States Secretary
13 of Health and Human Services a report concerning that accounting.
14 Commencing January 1, 2016, the board shall conduct an annual
15 audit.

16 (q) (1) Annually prepare a written report on the implementation
17 and performance of the Exchange functions during the preceding
18 fiscal year, including, at a minimum, the manner in which funds
19 were expended and the progress toward, and the achievement of,
20 the requirements of this title. The report shall also include data
21 provided by health care service plans and health insurers offering
22 bridge plan products regarding the extent of health care provider
23 and health facility overlap in their Medi-Cal networks as compared
24 to the health care provider and health facility networks contracting
25 with the plan or insurer in their bridge plan contracts. This report
26 shall be transmitted to the Legislature and the Governor and shall
27 be made available to the public on the Internet Web site of the
28 Exchange. A report made to the Legislature pursuant to this
29 subdivision shall be submitted pursuant to Section 9795.

30 (2) The Exchange shall prepare, or contract for the preparation
31 of, an evaluation of the bridge plan program using the first three
32 years of experience with the program. The evaluation shall be
33 provided to the health policy and fiscal committees of the
34 Legislature in the fourth year following federal approval of the
35 bridge plan option. The evaluation shall include, but not be limited
36 to, all of the following:

37 (A) The number of individuals eligible to participate in the
38 bridge plan program each year by category of eligibility.

39 (B) The number of eligible individuals who elect a bridge plan
40 option each year by category of eligibility.

1 (C) The average length of time, by region and statewide, that
2 individuals remain in the bridge plan option each year by category
3 of eligibility.

4 (D) The regions of the state with a bridge plan option, and the
5 carriers in each region that offer a bridge plan, by year.

6 (E) The premium difference each year, by region, between the
7 bridge plan and the first and second lowest cost plan for individuals
8 in the Exchange who are not eligible for the bridge plan.

9 (F) The effect of the bridge plan on the premium subsidy amount
10 for bridge plan eligible individuals each year by each region.

11 (G) Based on a survey of individuals enrolled in the bridge plan:

12 (i) Whether individuals enrolling in the bridge plan product are
13 able to keep their existing health care providers.

14 (ii) Whether individuals would want to retain their bridge plan
15 product, buy a different Exchange product, or decline to purchase
16 health insurance if there was no bridge plan product available. The
17 Exchange may include questions designed to elicit the information
18 in this subparagraph as part of an existing survey of individuals
19 receiving coverage in the Exchange.

20 (3) In addition to the evaluation required by paragraph (2), the
21 Exchange shall post the items in subparagraphs (A) to (F),
22 inclusive, on its Internet Web site each year.

23 (4) In addition to the report described in paragraph (1), the board
24 shall be responsive to requests for additional information from the
25 Legislature, including providing testimony and commenting on
26 proposed state legislation or policy issues. The Legislature finds
27 and declares that activities including, but not limited to, responding
28 to legislative or executive inquiries, tracking and commenting on
29 legislation and regulatory activities, and preparing reports on the
30 implementation of this title and the performance of the Exchange,
31 are necessary state requirements and are distinct from the
32 promotion of legislative or regulatory modifications referred to in
33 subdivision (d) of Section 100520.

34 (r) Maintain enrollment and expenditures to ensure that
35 expenditures do not exceed the amount of revenue in the fund, and
36 if sufficient revenue is not available to pay estimated expenditures,
37 institute appropriate measures to ensure fiscal solvency.

38 (s) Exercise all powers reasonably necessary to carry out and
39 comply with the duties, responsibilities, and requirements of this
40 act and the federal act.

1 (t) Consult with stakeholders relevant to carrying out the
2 activities under this title, including, but not limited to, all of the
3 following:

4 (1) Health care consumers who are enrolled in health plans.

5 (2) Individuals and entities with experience in facilitating
6 enrollment in health plans.

7 (3) Representatives of small businesses and self-employed
8 individuals.

9 (4) The State Medi-Cal Director.

10 (5) Advocates for enrolling hard-to-reach populations.

11 (u) Facilitate the purchase of qualified health plans in the
12 Exchange by qualified individuals and qualified small employers
13 no later than January 1, 2014.

14 (v) Report, or contract with an independent entity to report, to
15 the Legislature by December 1, 2018, on whether to adopt the
16 option in Section 1312(c)(3) of the federal act to merge the
17 individual and small employer markets. In its report, the board
18 shall provide information, based on at least two years of data from
19 the Exchange, on the potential impact on rates paid by individuals
20 and by small employers in a merged individual and small employer
21 market, as compared to the rates paid by individuals and small
22 employers if a separate individual and small employer market is
23 maintained. A report made pursuant to this subdivision shall be
24 submitted pursuant to Section 9795.

25 (w) With respect to the SHOP Program, collect premiums and
26 administer all other necessary and related tasks, including, but not
27 limited to, enrollment and plan payment, in order to make the
28 offering of employee plan choice as simple as possible for qualified
29 small employers.

30 (x) Require carriers participating in the Exchange to immediately
31 notify the Exchange, under the terms and conditions established
32 by the board when an individual is or will be enrolled in or
33 disenrolled from any qualified health plan offered by the carrier.

34 (y) Ensure that the Exchange provides oral interpretation
35 services in any language for individuals seeking coverage through
36 the Exchange and makes available a toll-free telephone number
37 for the hearing and speech impaired. The board shall ensure that
38 written information made available by the Exchange is presented
39 in a plainly worded, easily understandable format and made
40 available in prevalent languages.

(z) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 100503 of the Government Code, as added by Section 5 of Chapter 5 of the 1st Extraordinary Session of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

1 (d) Provide, in each region of the state, a choice of qualified
2 health plans at each of the five levels of coverage contained in
3 subsections (d) and (e) of Section 1302 of the federal act.

4 (e) Require, as a condition of participation in the Exchange,
5 carriers to fairly and affirmatively offer, market, and sell in the
6 Exchange at least one product within each of the five levels of
7 coverage contained in subsections (d) and (e) of Section 1302 of
8 the federal act. The board may require carriers to offer additional
9 products within each of those five levels of coverage. This
10 subdivision shall not apply to a carrier that solely offers
11 supplemental coverage in the Exchange under paragraph (10) of
12 subdivision (a) of Section 100504.

13 (f) (1) Require, as a condition of participation in the Exchange,
14 carriers that sell any products outside the Exchange to do both of
15 the following:

16 (A) Fairly and affirmatively offer, market, and sell all products
17 made available to individuals in the Exchange to individuals
18 purchasing coverage outside the Exchange.

19 (B) Fairly and affirmatively offer, market, and sell all products
20 made available to small employers in the Exchange to small
21 employers purchasing coverage outside the Exchange.

22 (2) For purposes of this subdivision, “product” does not include
23 contracts entered into pursuant to Part 6.2 (commencing with
24 Section 12693) of Division 2 of the Insurance Code between the
25 Managed Risk Medical Insurance Board and carriers for enrolled
26 Healthy Families beneficiaries or contracts entered into pursuant
27 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
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29 Welfare and Institutions Code between the State Department of
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18 officer, a director for the SHOP Exchange, a director of Health
19 Plan Contracting, a chief technology and information officer, a
20 general counsel, and other key executive positions, as determined
21 by the board, who shall be exempt from civil service.

22 (2) (A) The board shall set the salaries for the exempt positions
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24 in amounts that are reasonably necessary to attract and retain
25 individuals of superior qualifications. The salaries shall be
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32 most comparable to the Exchange.

33 (ii) Other relevant labor pools.

34 (B) The salaries established by the board under subparagraph
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36 of that type, as determined by the surveys conducted pursuant to
37 subparagraph (A).

38 (C) The Department of Human Resources shall review the
39 methodology used in the surveys conducted pursuant to
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1 (3) The positions described in paragraph (1) and subdivision (i)
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4 and, for those purposes, the Exchange shall not be considered a
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19 Commencing January 1, 2016, the board shall conduct an annual
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8 (t) Consult with stakeholders relevant to carrying out the
9 activities under this title, including, but not limited to, all of the
10 following:

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15 individuals.

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18 (u) Facilitate the purchase of qualified health plans in the
19 Exchange by qualified individuals and qualified small employers
20 no later than January 1, 2014.

21 (v) Report, or contract with an independent entity to report, to
22 the Legislature by December 1, 2018, on whether to adopt the
23 option in Section 1312(c)(3) of the federal act to merge the
24 individual and small employer markets. In its report, the board
25 shall provide information, based on at least two years of data from
26 the Exchange, on the potential impact on rates paid by individuals
27 and by small employers in a merged individual and small employer
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30 maintained. A report made pursuant to this subdivision shall be
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33 administer all other necessary and related tasks, including, but not
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35 offering of employee plan choice as simple as possible for qualified
36 small employers.

37 (x) Require carriers participating in the Exchange to immediately
38 notify the Exchange, under the terms and conditions established
39 by the board when an individual is or will be enrolled in or
40 disenrolled from any qualified health plan offered by the carrier.

- 1 (y) Ensure that the Exchange provides oral interpretation
2 services in any language for individuals seeking coverage through
3 the Exchange and makes available a toll-free telephone number
4 for the hearing and speech impaired. The board shall ensure that
5 written information made available by the Exchange is presented
6 in a plainly worded, easily understandable format and made
7 available in prevalent languages.
- 8 (z) This section shall become operative only if Section 4 of the
9 act that added this section becomes inoperative pursuant to
10 subdivision (z) of that Section 4.

O